Town of Florence
775 N. Main Street, P O Box 2670, Florence, AZ 85132

INCIDENT REPORT

Risk Management Use Only: Town Incident # _____

Liability: Property Loss/Damage:_____ Auto Loss/Damage:_____

SECTION I

(Complete in full)

Incident Information

Reporting Date:_____ Date of Incident:_____

Location of Incident:_____

City:_____ State:_____ Zip:_____

Type of Loss: (Auto, Property, Injury, Fire, Wind, Etc.)_____

Describe what happened:_____

_____

Employee Involved in Incident:_____

Contact Person for Additional Information:_____

Witness/Passenger Name(s):_____

Address:_____ Phone #_____

Was a Police Report Filed: Yes:_____ No_____ Report #_____

Where Filed:_____

SECTION II

(Complete Section A and B)

A. Municipal Vehicle Information (For Auto/Motorized Equipment Loss/Damage)

Plate:_____ VIN:_____ Vehicle #_____

Year:_____ Make:_____ Model #_____

Driver's Name:_____ Department:_____

Describe Damage:_____

_____

Where can vehicle be seen?_____

B. Other Vehicle Information

Year:_____ Plate:_____ VIN:_____

Make: _____ Model:_____

Owner's Name: _____

Address: _____ Phone:_____

City, State, Zip: _____

Driver's Name: _____

Address: _____ Phone:_____

City, State, Zip: _____

Describe how accident occurred:_____

Describe Damage:_____

SECTION III

(Complete Section A and B)

For other Municipal Losses

A. Property Loss/Damage:

Owner's Name:_____

Address: _____ Phone:_____

City, State, Zip: _____

Description of Lost/Damaged Property:_____

If Town Owned: Serial Tag #_____ Estimated Damage:_____

Repair:_____ Replace:_____

B. Injury/Incident:

Injured Name: _____

Address: _____ Phone: _____

City, State, Zip: _____

Nature & Extent of Injury/Accident: _____

_____

Exact Location of Injury/Accident: _____

_____

Cause of Injury/Accident: _____

_____

Was person given first-aid? Yes: _____ No: _____

If yes, describe first-aid treatment administered: _____

Sent for medical treatment: Yes: _____ No: _____

If Yes, where? _____

FOR PARKS AND RECREATION USE ONLY:

Age of participant: _____ Parent/Guardian Name: _____

Program Name: _____ Location: _____

Program Supervisory Ratio: _____ No. of Program Participants: _____

Fill in where applicable:

___Attended by Doctor: Name: _____ Time: _____

___Removed to Hospital Name: _____ Time: _____

___Parents Notified Name: _____ Time: _____

___Parent/Person who picked up child: Name: _____ Time: _____

PLEASE ATTACH COPY OF SIGNED WAIVER RELEASE FORM IF APPLICABLE

Reported by: _____ Date: _____

Department Head Signature: _____ Date: _____